

WELCOME

Patient Information

Insurance

Date ____/____/____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate ____/____/____

Single Married Widowed Separated Divorced

Patient Social Security Number _____

Occupation _____

Employer _____

Employer Phone _____

Children's Name(s)/Age _____

E-Mail: _____

Whom may we thank for referring you? _____

Have you ever received treatment by a Chiropractor before? Yes No

If yes, when and who? _____

Primary Care Physician _____

May we send the doctor a report? Yes No

Insurance Company _____

Subscriber's Name _____

Birthdate ____/____/____ SS# _____

ASSIGNMENT AND RELEASE:

I hereby direct any and all insurance carriers, attorneys, and individuals to directly pay Reynoldsburg Chiropractic Center for charges incurred by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Phone Numbers

HIPAA NOTICE

Home _____ Work _____ Ext _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's signature _____ Date _____

Guardian's signature _____ Date _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching

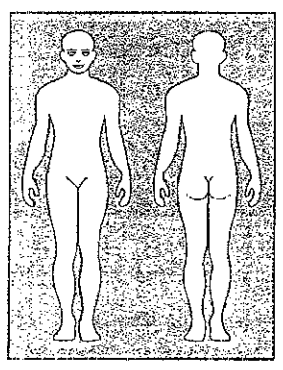
Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Chiropractic Services Medications Surgery
 Physical Therapy None Other _____

Name of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
 MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|---------------------|--|----------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

OTHER: _____

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____ Pharmacy Phone _____		

Tear off this sheet and return completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.



First Report of an Injury, Occupational Disease or Death

WARNING:
 Any person who obtains compensation from BWC or self-insuring employers by: knowingly misrepresenting or concealing facts, making false statements, or accepting compensation to which he/she is not entitled, is subject to felony criminal prosecution for fraud
 (R.C. 2913.48)

Last name first name - middle initial			Social Security number		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth		
Home mailing address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of dependents			
City		State	9-digit ZIP code		Country if different from USA		Department name		
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat			Regular work hours From _____ To _____			
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain.							Occupation or job title		
Employer name									
Mailing address (number and street city or town state ZIP code and county)									
Location if different from mailing address									
Was place of accident or exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, give accident location, street address, city, state and ZIP code)									
Date of injury/disease		Time of injury <input type="checkbox"/> AM <input type="checkbox"/> PM		If fatal give date of death		Time employee began work _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Date last worked	Date returned to work
Date hired			State where hired			Date employer notified			
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death)						Type of injury/disease and part(s) of body affected (For example: sprain of lower left back, etc.)			
<p><i>Benefit Application/Medical Release - I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related causally or historically to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio. The employer listed in this claim, that employer's managed care organization, and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is related causally and historically to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties</i></p>									
Injured worker signature				Date		Telephone number () ()		Work number ()	

Health care provider name			Telephone number () ()		Fax number () ()		Initial treatment date	
Street address				City		State		9-digit ZIP code
Diagnosis(es); Include ICD code(s)								
Will the incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> YES <input type="checkbox"/> NO				Is the injury causally related to the industrial incident? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Health care provider signature				11-digit BWC provider number			Date	

Employer policy number			CHECK IF:		<input type="checkbox"/> Employer is self-insuring			
					<input type="checkbox"/> Injured worker is Owner/Partner/Member of Firm			
Telephone number () ()		Fax number () ()		E-mail address		Federal ID number		Manual number
Was employee treated in an emergency room? <input type="checkbox"/> YES <input type="checkbox"/> NO				Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If treatment was given away from worksite provide the facility name street address city state ZIP code								
<input type="checkbox"/> CERTIFICATION - The employer certifies that the facts in this application are correct and valid				<input type="checkbox"/> REJECTION - The employer rejects the validity of this claim for the following reason(s) below:			FOR SELF-INSURING EMPLOYERS ONLY:	
							<input type="checkbox"/> CLARIFICATION - The employer clarifies and allows the claim for the condition(s) below:	
Employer signature and title						Date		OSHA case number